

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County DorchesterCity or town Vienna - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Indiantown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Vienna - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Indiantown Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Sophonina N. Bradley

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Henry Bradley7. Birth date of deceased (mo., day, yr.) June 1, 1876

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

69 2 3 hrs. min.9. Birthplace Dorchester County, Maryland
(Town, county, and state)10. Usual occupation Housework11. Industry or business Home12. Name Thomas Marine13. Birthplace Dorchester County, Maryland14. Maiden name Elizabeth Fischer15. Birthplace Dorchester County, Maryland16. Informant Mrs. J. Graham CraverAddress Richmond, Virginia17. Burial Date hereof August 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brookview CemeteryLocation Brookview, Maryland18. Funeral director J.J. Frampton and SonAddress Federalburg, Maryland19. Aug 6 - 1945 Charles H. Hatcher
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1945 to Aug 4, 1945and that I last saw him/her alive on Aug 1, 1945

Immediate cause of death

Embolic blockage ofCoronary ArteryDue to Coronary Artery DiseaseDue to Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE W. H. Hatcher M. D. or otherAddress Richmond, Virginia Date signed Aug 6 - 1945

RECEIVED

AUG 14 1945

BUREAU

Evidence for addition of
sex & color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM NO. G 97 SEP 5 1945

CERTIFICATE OF DEATH

07978
Reg. Dist. No. 116

1. PLACE OF DEATH

County Dorchester
City or town Cambridge Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Cambridge Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Minney Bramoch

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mary B Bramoch

6. (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) P. 1870

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Taylor Island Md
(Town, county, and state)

10. Usual occupation Salvager

11. Industry or business

12. Name Dont know

13. Birthplace

14. Maiden name Dont know

15. Birthplace

16. Informant Heida Bramoch

Address Cambridge Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 26 / 45
(month) (day) (year)

Cemetery or crematory Cemetery

Location Taylor Island Md

18. Funeral director Spaid H. Baymen

Address Cambridge Md

19. 8-27- 45 John R. Ruppel, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1945 to Aug 23 1945; and that I last saw him alive on Aug 17 1945.

Immediate cause of death Cerebral Hemorrhage

DURATION

21 days

Due to

Due to

Other conditions Alcohol

1942

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Carol M. R. Clear

M. D. or other

Address Cambridge Md Date signed 8-25-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

ms

RECEIVED
AUG 29 1945
BUREAU V.B.

UNITED STATES GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4002

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Rockchester
City or town Cambridge Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 days

3. (a) FULL NAME

William J. Chesneau

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 1st 1878

8. AGE:

67 years

Months

1

Days

22nd

If less than one day

hrs. min.

9. Birthplace

Retired Merchant
(Town, county, and state)

10. Usual occupation

11. Industry or business

William J. Chesneau

12. Name

13. Birthplace

Mary Ellen Moore

14. Maiden name

15. Birthplace

Elmerod Chesneau

Address

Madison

17. (Burial, cremation, or removal, which?)

Burial

Cemetery or crematory

East View Cemetery

18. Funeral director

A. B. Willoughby

Address

East View Cemetery

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 30 1945 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

August 29 1945 to Aug. 30 1945

and that I last saw him alive on August 30 1945

Immediate cause of death

TOXIC MYOCARDITIS

DURATION

2 days

Due to

GANGRENE RT. FOOT

62 days

Due to

DIABETES MELLITUS

Other conditions

ADENOCARCINOMA

RECTUM

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

SIGNATURE

W. J. Chesneau
Cambridge, Md.

M. D. or

8/30/45

Address

Date signed

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED

RECEIVED
SEP 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07980

Reg. Dist. No. 190

1. PLACE OF DEATH:

County Dorchester
 City or town Beltsville Md. - near Federal Rd.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs.
 Hospital, institution, or street address where death occurred:
2340
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Beltsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. near Seaford Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Mrs Roxie Duke

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Willie F. Duke
deceased

7. Birth date of

deceased (mo., day, yr.) April 12, 1977

8. AGE: Years Months Days If less than one day

68 4 14 hrs. min.

9. Birthplace

near Federalburg
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Wm. J. Morgan13. Birthplace Maryland14. Maiden name Mary E. Lizabeth Andrew15. Birthplace Maryland16. Informant Mrs. Mary BurgAddress Wilmington, Delaware17. Burial Date thereof Aug 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bloomery CemeteryLocation near Federalburg18. Funeral director Harvey WilliamsAddress Federalburg, Md.19. Aug 30 19 45 Charles H. Hestings
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 26 19 45 to Aug 26 19 45and that I last saw him alive on Aug 26 19 45

Immediate cause of death

Cerebral HemorrhageDue to Active Sclerosis

Due to

Other conditions High blood pressure

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. B. AllenAddress Seaford Del M. D. or otherDate signed Aug 27/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 1 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

07981

CERTIFICATE OF DEATH



Reg. Dist. No. 116

1. PLACE OF DEATH:

County.....Dorchester
 City or town.....Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....6 mos. 25 ds
 Hospital, institution, or street address where death occurred:
 Eastern Shore State Hosp.
 How long in hospital or institution?.....6 mos 2 ds

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland
 City or town.....Chesterville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....no

3. (a) FULL NAME

Harry E Dwyer

3. (b) Social Security Number
none

4. Sex.....Male
 5. Color or race.....White
 6.(a) Single, married, widowed, or divorced.....Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age.....years
 7. Birth date of deceased (mo., day, yr.).....December 13 1895
 8. AGE: Years.....49 Months.....8 mos Days.....14 It less than one day.....hrs.min.

9. Birthplace.....Worton Kent Maryland
(Town, county, and state)

10. Usual occupation.....Laborer

11. Industry or business

12. Name.....William Dwyer
 13. Birthplace.....Kent County Mar Land
 14. Maiden name.....Mary R. England
 15. Birthplace.....Kent Cy. Maryland

16. Informant.....Hospital Records
 Address.....Cambridge Maryland

17. Burial Date thereon Aug 30 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....CHESTER VILLE, CEM.
 Location.....KENT Co. Md.

18. Funeral director.....J. Willis Wells
 Address.....Chestertown, Md.

19. 8-27-45 John Mayhew M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....August 27 1945 at 10.45M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 February 2 1945 to August 27 1945
 and that I last saw him alive on August 27 1945

Immediate cause of death.....Chronic Myocarditis & Myocardial Degeneration
 Due to.....Arteriosclerosis

Due to.....

Other conditions.....Chronic Bronchitis
 Emphysema
 (Include pregnancy within 3 months of death) unknown

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?.....

23. SIGNATURE.....
 Address.....Cambridge Md Date signed.....August 27

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AUG 30 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07982

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Hurlock - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
P.W. Camp No. 5
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Hurlock - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.W. Camp No. 5
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3.(a) FULL NAME

George Ehgantner

3.(b) Social Security Number

31-6-1823484

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced ?
 8.(b) Name of husband or wife ?
 7. Birth date of deceased (mo., day, yr.) 1904 8.(c) If alive, give age..... years
 8. AGE: Years 41 Months # Days # If less than one day # hrs. # min.

9. Birthplace Germany
(Town, county, and state)10. Usual occupation W. P.

11. Industry or business

FATHER 12. Name ?
 13. Birthplace ?
 MOTHER 14. Maiden name ?
 15. Birthplace

16. Informant Camp Records
 Address P.W. Camp #5 - Hurlock

17. (Burial, cremation, or removal. Which?) 26 Aug 16 1945
 Date thereof (month) (day) (year)
 Cemetery or crematory Ft. Coo Mounds
 Location M.D.

18. Funeral director H.B. Brown
 Address Ft. Coo Mounds

19. Aug. 14 19 45 Chas. W. Hastings
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 19 45 at 10:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

Gas - EmbolismDue to Potomac ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. H. Shriver Dep. Med. Exam.
 M. D. or other
 Address Camp bridge - Md. Date signed Aug 14/45

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED
AUG 16 1945
BUREAU U.S.

MAILED 15 - AUG 16 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown 2411 N. Charles St., Baltimore 488

on FILM No. G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

07984

★ Reg. Dist. No. 116

1. PLACE OF DEATH:

County... Dorchester
City or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Dorchester
City or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Pine St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ella Fitzgiles

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William Fitzgiles

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1895 - 1891 6.(c) If alive, give age... years

8. AGE: Years 54 Months 6 Days 2 If less than one day

9. Birthplace Sharptown Wic. Co. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Daniel R. Shockley

13. Birthplace Somerset Co. Md

14. Maiden name Mary Sheppard

15. Birthplace Somerset Co. Md.

16. Informant Henry Shockley

Address Cambridge, Md

17. Burial Burial Date thereof Aug 16 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waucho Cemetery

Location Cambridge Md

18. Funeral director W. M. Sullivan & Son

Address Cambridge, Md

19. (Date rec'd by registrar) 8-13-45 Registrar John M. ...

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 3:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7 1942, to August 13 1945

and that I last saw him alive on August 13 1945

Immediate cause of death Cancer of Uterus

DURATION 8 mos

Due to

Due to

Other conditions Angina 10 mos

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Conroy M. ... M. D. or other

Address Cambridge Md Date signed 8-16-45

RECEIVED
AUG 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 46

07983

CERTIFICATE OF DEATH

Reg. Diat. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Cambridge Md. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Madison
(If outside city or town limits, write RURAL and give nearest town)Street No. none
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas C. Fitzhugh

3. (b) Social Security Number

220-16-9997

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

B.(b) Name of husband or wife

Fannie Woodford

7. Birth date of

deceased (mo., day, yr.)

Dec. 3-1885

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59827

hrs.

min.

9. Birthplace

Madison
(Town, county, and state)

10. Usual occupation

Farmer, Waterman

11. Industry or business

Lumberman

12. Name

John R. Fitzhugh

13. Birthplace

Madison

14. Maiden name

Christine Andrews

15. Birthplace

Fakesville, Dor Co

16. Informant

Mrs. Thos C Fitzhugh

Address

Madison, Md.

17. Burial

Madison M. E. Churchyard

18. Location

Cambridge, Md.

19. Funeral director

Remeth R Thomas

Address

Cambridge, Md.

9-1-19

19

Date rec'd by registrar

John Macg...

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945 at 12:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 1945 to Aug 30 1945and that I last saw him alive on Aug. 29 1945

Immediate cause of death

Basinoma of liverDue to unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

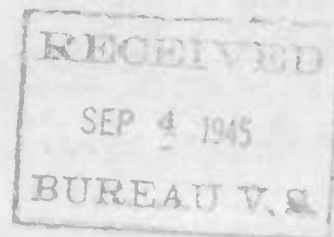
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. O. Meredith, M.D.Address Cambridge, Md.Date signed Aug. 30, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07985

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 Years

Hospital, institution, or street address where death occurred:

200 High St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 High St.

(If rural, give LOCATION)

2.(a) If veteran, name war -

3.(a) FULL NAME

Edward W. Gibbons

3.(b) Social Security Number

-4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Elizabeth MarshallLeCompte Gibbons 6.(c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) Dec. 30, 18608. AGE: Years 84 Months 7 Days 10 If less than one day
.....hrs.min.9. Birthplace Baltimore County
(Town, county, and State)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Isiah Gibbons13. Birthplace Maryland14. Maiden name Elizabeth Young15. Birthplace Maryland16. Informant Mrs. E. W. GibbonsAddress 200 High St., Cambridge, Md.17. Burial Aug. 13, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Christ Church CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. Aug 13- 19 45 John Marshall
(Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10th 19 45 at 3:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23rd 19 40 to Aug 10 19 45 and that I last saw him alive on Aug 6 19 45Immediate cause of death Cerebral Hemorrhage DURATION 15 min.Due to Atherosclerosis
Cardiovascular Renal
Due to Dissecting 5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldridge H. H. H. H. M. D. of otherAddress Cambridge, Md. Date signed 8-11-45

RECEIVED

AUG 16 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07986

★ Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? -

Hospital, institution, or street address where death occurred:

13 Cherry St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 13 Cherry St.
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Herman Everett Gootee

3. (b) Social Security Number

220-10-6755

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lottie Lane Gootee6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1883

8. AGE:

Years 61Months 11Days 4

If less than one day

hrs. min.

9. Birthplace Drawbridge, Dor. Co., Maryland.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name John W. Gootee13. Birthplace MarylandMOTHER 14. Maiden name Martha P. Sellers15. Birthplace Maryland.16. Informant Mrs. Lottie GooteeAddress 13 Cherry St. & Cambridge, Md.17. Burial Date thereof Aug. 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dorchester Memorial ParkLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 8/29 1945
(Date rec'd by registrar)John Hance Jr. M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1945 at 10:05 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1945 to August 28 1945and that I last saw him alive on August 28 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

4 daysDue to Myocardial infarction withauricular fibrillationDue to Arteriosclerosis withhypertensionOther conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Albert E. BrunerAddress Cambridge Md. Date signed 8-28-45

RECEIVED
AUG 30 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1406)

CERTIFICATE OF DEATH

 07987
 ★ Reg. Dist. No. 16

1. PLACE OF DEATH:

County... WorcesterCity or town... Cambridge Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Cambridge Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Roslyn Ave.
(If rural give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Hilda A. Gordon

3. (b) Social Security Number

214-07-8692

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 10, 1920
8. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
24 10 6 _____ hrs. _____ min.9. Birthplace... Cambridge Md.
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... John W. Gordon13. Birthplace... Barren Is. Dor. Co.14. Maiden name... Winnie M. Price15. Birthplace... Cambridge, Md.16. Informant... John W. GordonAddress... Cambridge Md.17. Burial Date thereof Aug 19, 1945
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory... CambridgeLocation... Cambridge Md.18. Funeral director... Kenneth R. ThomasAddress... Cambridge, Md.19. 8/18/45 19 45 James
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 16, 1945 at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15, 1945 to Aug. 16, 1945and that I last saw him alive on August 16, 1945

Immediate cause of death

MYOCARDIAL FAILURE DURATION 1 dayDue to... TOXEMIA OF PERITONITISDue to... Clostridium Welchii INFECTION OF SEPTIC ABORTION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... PERITONITIS - Clostr. WelchiiDate of op. 8/10/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ?

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. J. Banks M. D. or otherAddress... Cambridge Md. Date signed 8/18/45

RECEIVED
AUG 29 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

07988

CERTIFICATE OF DEATH

★ Reg. Dist. No. 116

1. PLACE OF DEATH: *Dorchester*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*1 day*
 Hospital, institution, or street address where death occurred:
Phillip Recreation Park
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Somerset*
 City or town.....*Crisfield*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*817 West Main St*
 (If rural, give LOCATION)
 2(a) If veteran, same war.....

3. (a) FULL NAME *Morris Edward Grant* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *Col.* 6. (a) Single, married, widowed, or divorced *married*
 6. (b) Name of husband or wife.....*Alveta Merrill*
 6. (c) If alive, give age.....*25* years
 7. Birth date of deceased (mo., day, yr.) *July 15 - 1920*
 8. AGE: Years *25* Months *-* Days *19* If less than one day.....hrs. min.

9. Birthplace.....*Crisfield - Md.*
 (town, county, and state)
 10. Usual occupation.....*Laborer*

11. Industry or business
 12. Name.....*Charles Glad - Md*
 13. Birthplace.....*Md*
 14. Maiden name.....*Essena Grant*
 15. Birthplace.....*Md*

16. Informant.....*Alveta Grant*
 Address.....*817 Main St. Crisfield - Md.*

17. Burial.....*Burial* Date thereof.....*Aug. 7 - 1945*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....*Lawsonia Cemetery*
 Location.....*Crisfield Md*
Alvaron Bradshaw

18. Funeral director.....*Crisfield, Md*
 Address.....

19. *8-7-* 19 *45* *John M. J. M.D.*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*August 5* 19*45* at *5:45 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19....., to.....19.....
 and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Coronary Disease* DURATION *1 day*

Due to.....
 Due to.....

Other conditions.....*Pratt's Exophthalmic Goiter*
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Dr. H. Shivers, Dep. Med. Exam.*
 M. D. or other
 Address.....*Cranbridge - Md* Date signed *Aug. 7, 45*

RECEIVED

AUG 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

07989

CERTIFICATE OF DEATH

★ Reg. Dist. No. 16

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 16 days
Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
How long in hospital or institution? 1 yr., 3 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Willow Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Claude M. Henderson

3. (b) Social Security Number

213-05-1970

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Joda Henderson
7. Birth date of deceased (mo., day, yr.) April 19, 1892
6. (c) If alive, give age 51 years
8. AGE: Years 53 Months 3 Days 17 If less than one day
.....hrs.min.

9. Birthplace Somerset County, Maryland
(Town, county, and state)
10. Usual occupation Garden Filling Station Attendant
11. Industry or business Retail Sales

FATHER 12. Name Henry Henderson
13. Birthplace Maryland
MOTHER 14. Maiden name Amanda Herrill
15. Birthplace Maryland

16. Informant Hospital Records
Address E.S.S.H., Cambridge, Md.

17. Burial Date thereof August 8, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Belton M.E. Cemetery
Location Pocomoke City Md.
18. Funeral director Margaret H. Johnson
Address Pocomoke City Md.
19. 8-8- 19 45 John H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 19 45, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19....., to.....19.....
and that I last saw him.....alive on.....19.....

Immediate cause of death Suffocation (drowning) on 8/6/45
DUE TO Probable apoplexy

Other conditions Post-traumatic mental deterioration since 5/5/43
(Include pregnancy within 3 months of death)
Major findings of operations.....Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/6/45
Where did injury occur? Cambridge, Dorchester, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Eastern Shore State Hospital
Means of Injury Apoplectic attack Injured at work? No

23. SIGNATURE Dr. H. Shriver, Dep. Med. Exam
M. D. or other
Address Cambridge, Md. Date signed Aug 6/45

RECEIVED

AUG 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *SP*

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

07990

1. PLACE OF DEATH:

County *Dorchester*City or town *Cambridge*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Life*

Hospital, institution, or street address where death occurred:

*Cambridge Maryland Hospital*How long in hospital or institution? *3 wks.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Dorchester*City or town *Cambridge*
(If outside city or town limits, write RURAL and give nearest town)Street No. *Oakley St.*
(If rural, give LOCATION)2.(a) If veteran, name war *Retired Rear Admiral U.S. Navy*

3. (a) FULL NAME

Thomas Halliday Hicks

3. (b) Social Security Number

| | | |
|-----------------------|----------------------------------|--|
| 4. Sex <i>Male</i> | 5. Color or race <i>White</i> | 6.(a) Single, married, widowed, or divorced <i>Single</i> |
|-----------------------|----------------------------------|--|

6.(b) Name of husband or wife *Single*

7. Birth date of deceased (mo., day, yr.)

Sept. 8, 1869.

6.(c) If alive, give age.....years

| | | | | |
|---------|-----------|-----------|-----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <i>75</i> | <i>10</i> | <i>28</i> |hrs.min. |

9. Birthplace *Nech Dist. Dor Co. Maryland.*
(Town, county, and state)10. Usual occupation *Retired Admiral*11. Industry or business *U.S.N.*12. Name *George Luther Hicks*13. Birthplace *MO.*14. Maiden name *Mary Rebecca Hicks*15. Birthplace *MO.*16. Informant *Mrs. Chaplain Hicks*Address *High St., Cambridge, MO.*17. *Burial* Date thereof *Aug. 8, 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Cambridge Cemetery*Location *Cambridge, Maryland*18. Funeral director *Le Comptes Funeral Service*Address *Cambridge, Maryland.*19. *8-8-45* (Date rec'd by registrar)

19.

John Mace Jr. M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 4, 1945* at *6:45 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to *Aug. 6, 1945*
and that I last saw him alive on *Aug. 6, 1945*Immediate cause of death *Crown an Occurrence*

DURATION

Due to.....

Due to.....

Other conditions

Carcinoma of Prostate

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *no* Date ofWhere did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

Guy Steele M.D.
Address *Cambridge Md.*

M. D. or other

Date signed *8-7-45*

Robert K. Hugglett

RECEIVED

AUG 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 272

CERTIFICATE OF DEATH

07991

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Rural--Andrews
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Home--AndrewsHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural--Andrews
(If outside city or town limits, write RURAL and give nearest town)Street No. Andrews
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Octavia Sophrana Burton Hurley

3. (b) Social Security Number

-4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Walter Hurley6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) Sept. 20, 18708. AGE: Years 74 Months 10 Days 28 It less than one day
.....hrs.min.9. Birthplace Andrews, Dor. Co., Maryland
(Town, county, and state)10. Usual occupation Practical Nurse11. Industry or business Nursing12. Name Not Known13. Birthplace Not Known14. Maiden name Not Known15. Birthplace Not Known16. Informant Mrs. Emerson SlacumAddress Andrews, Maryland.17. Burial Date thereat Aug. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Slacum Family CemeteryLocation Lakesville, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 8-31- 19 45 John M. J. M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 18, 1945 at 9:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1945, to Aug 15 1945and that I last saw her alive on Aug 15 1945Immediate cause of death Sudden Respiratory(Emphysema)Due to EmphysemaDue to EmphysemaOther conditions Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations EmphysemaDate of op. Aug 15Autopsy results Emphysema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Emphysema Date of Aug 15Where did injury occur? Emphysema (City or town) (County) (State)Injured at home, farm, industry, public place (where?) EmphysemaMeans of injury Emphysema Injured at work? Emphysema23. SIGNATURE P. H. T. T. T. M. D. or otherAddress Cambridge, Md. Date signed Aug 19, 1945

RECEIVED
AUG 29, 1945
BUREAU V.P.

RECEIVED
AUG 29 1945
BUREAU V.P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

CERTIFICATE OF DEATH

07992

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge, Pauley
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Pauley
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mary Jackson

3. (b) Social Security Number

4. Sex

female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife:

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1885

8. AGE:

Years

Months

Days

If less than one day

60021hrs.min.

9. Birthplace:

Annapolis, Md.

(Town, county, and state)

10. Usual occupation:

Sanitation work

11. Industry or business

FATHER

12. Name

Joseph Hopkins

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary (P)

15. Birthplace

Maryland

16. Informant

John Mortimer

Address

Cambridge, Pauley, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

8-8-40

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

8-7-40John Mortimer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 61945, at 6:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 1945, to August 6 1945;
 and that I last saw alive on August 6 1945.

Immediate cause of death

Chs. Bronchitis
Arteriosclerosis
Chs. Myocarditis
Aortic Aneurysm

Due to

Due to

Other conditions

Sen. Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Corroll M. St. Clair M.D.

M. D. or other

Address

One Cedar St.Date signed 8-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPORT TO THE STATE OF NEW YORK

STATE OF NEW YORK

RECEIVED
AUG 9 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1546

07993



Reg. Dist. No. 116

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Sarah Jane Jackson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Samuel R. Jackson

7. Birth date of

deceased (mo., day, yr.)

Aug. 1, 1894

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71

0

11

.....hrs.

.....min.

9. Birthplace.....

Cambridge, Md.
(Town, county, and state)

10. Usual occupation.....

Laundress

11. Industry or business.....

MOTHER FATHER

12. Name.....

Moses Camper

13. Birthplace.....

Aixey's Dor. Co. Md.

14. Maiden name.....

Frances Jennifer

15. Birthplace.....

Cambridge, Dor. Co. Md

16. Informant.....

Mrs Nante Eaddy

Address.....

Easton, Talbot Co. Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Aug 16 1945
(month) (day) (year)

Cemetery or crematory.....

Naugh Cemetery

Location.....

Cambridge Dor. Co. Md

18. Funeral director.....

H. McAllister & Son

Address.....

Cambridge, Md

19. (Date rec'd by registrar)

8-16-45

John Mauch and

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 13 1945 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1945 to Aug 13 1945

and that I last saw her alive on

August 13 1945

Immediate cause of death.....

MYOCARDIAL FAILURE

DURATION

6 days

Due to.....

TOXEMIA -

Due to.....

OSTEOMYELITIS RT. LOWER
EXTREMITY.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Cambridge, Md

M. D. or other

Date signed

8/14/45

REC

AUG 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bto*

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

1. PLACE OF DEATH:

County... *Dorchester*
 City or town... *Cambridge, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *47 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County... *Dorchester*
 City or town... *Cambridge*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... *504 Washington St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war... *none*

3.(a) FULL NAME

H. Phillips Kraft

3.(b) Social Security Number

14-07-9990

4. Sex... *male* 5. Color or race... *white* 6.(a) Single, married, widowed, or divorced... *married*

6.(b) Name of husband or wife... *Lillie Marshall*

7. Birth date of deceased (mo., day, yr.)... *October 31, 1896* 5.(c) If alive, give age... *47* years

8. AGE: Years... *48* Months... *9* Days... *7* If less than one day... hrs. min.

9. Birthplace... *Chaptank, Caroline Co.*
 (Town, county, and state)

10. Usual occupation... *Short Factory Operator*

11. Industry or business

12. Name... *J. Harry Kraft*

13. Birthplace... *Cambridge, Md.*

14. Maiden name... *Elizabeth Phillips*

15. Birthplace... *Kent Co. Md.*

16. Informant... *Mrs. H. Phillips Kraft*

Address... *Cambridge Md*

17. Burial... *Burial* Date thereof... *8-11-45*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... *Dorchester Memorial Park*

Location... *Cambridge Md.*

18. Funeral director... *Samuel H. Thomas*

Address... *Cambridge Md*

MEDICAL CERTIFICATION

20. DATE OF DEATH... *August 8* 19... *45* at... *3:15* PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... *July 1* 19... *45* to... *Aug 8* 19... *45*

and that I last saw him alive on... *Aug 8* 19... *45*

Immediate cause of death... *Acute Coronary*

Infarction

Due to... *Coronary - Reme*

Due to... *Coronary*

Other conditions... *none*

(Include pregnancy within 3 months of death)

Major findings of operations... *none*

Date of op... *none*

Autopsy results... *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... *none* Date of... *none*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... *none* Injured at work?

23. SIGNATURE... *John F. Emery*

Address... *Cambridge Md* Date signed... *8-9-45*

RECEIVED
AUG 16 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 118

CERTIFICATE OF DEATH

07995
Reg. Dist. No. 111

1. PLACE OF DEATH:

County Dorchester
City or town East New Market Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 years
Hospital, institution, or street address where death occurred:
none
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town East New Market Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Magdalene Elbert Mason

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
B.(b) Name of husband or wife John Mason
7. Birth date of deceased (mo., day, yr.) Jan. 24, 1902 6.(c) If alive, give age _____ years
8. AGE: Years 43 Months 6 Days 24 If less than one day _____ hrs. _____ min.
9. Birthplace East New Market Md
(Town, county, and state)
10. Usual occupation none

11. Industry or business

FATHER 12. Name Aaron Pasfield
13. Birthplace Md
MOTHER 14. Maiden name Mellie Nichols
15. Birthplace Caroline Co.

18. Informant Mellie Jenkins
Address East New Market Md
17. Burial Date thereof 8/18/45
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location East New Market Md

18. Funeral director A.B. Hurlingham
Address Hurlingham

19. 8/18/45 19. Elizabeth C. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 19 45 at 1³⁰ A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 19 45 to — 19 45
and that I last saw her alive on Aug 6 19 45

Immediate cause of death Indigestion, acute DURATION 6 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R.D. Brown M.D. M. D. or other _____

Address East New Market Date signed 8/18/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
SEP 6 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07996

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

AUG 30 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07997

Reg. Dist. No. 116

1. PLACE OF DEATH
 County Dorchester
 City or town Cambridge Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Dor.
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Gulf St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Emma Plater

3. (b) Social Security Number

4. Sex female 5. Color or race Col 6. (a) Single, married, widowed, or divorced widow
 6. (b) Name of husband or wife George Plater
Oct 14 6. (c) If alive, give age Dead years
 7. Birth date of deceased (mo., day, yr.) *

8. AGE: Years Months Days If less than one day
 .hrs. mto.

9. Birthplace Cambridge Md
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Vergil Nichols
 13. Birthplace Maryland

MOTHER 14. Maiden name Julia Foxworth
 15. Birthplace Maryland

16. Informant Fred Chester
 Address Pine St Cambridge

17. Burial Date thereof Sept 2 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery
 Location Christ Church

18. Funeral director Sam H. Bryman
 Address Cambridge Md

19. 9/1 19 45 John H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH August 27. 1945 at 1:35 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 19 45 to Aug 27 19 45
 and that I last saw h. ER alive on Aug 27 19 45

Immediate cause of death Myocardial
Failure

Due to Cachexia
gastrointestinal
Stomach

Other conditions Rheumatoid arthritis
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE H. H. H.
 Address Cambridge Md Date signed 9/3/45

RECEIVED

SEP 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07998

Reg. Dist. No. 116

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
104 Robbins St.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Robbins St.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME
Granville Pritchett

3. (b) Social Security Number
-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Libby May Mills
6. (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) July 7, 1891
8. AGE: Years 54 Months 1 Days 22 If less than one day - hrs. - min.

9. Birthplace Bishops Head, Dor. Co., Md.
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business Grocery Store
12. Name John W. Pritchett
13. Birthplace Maryland
14. Maiden name Susan Lewis
15. Birthplace Maryland

16. Informant Weldon Pritchett
Address 104 Robbins St., Cambridge, Md.
17. Burial Burial Date thereof Sept. 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenlawn Cemetery
Location Cambridge, Maryland.
18. Funeral director LeCompte's Funeral Service
Address Cambridge, Maryland.

19. 9-1-45 19 45 John M. ...
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945 at 5:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 19 45 to Aug. 29 19 45
and that I last saw him alive on August 29 19 45

Immediate cause of death Myocardial Failure DURATION 3 days
Due to BRONCHIAL ASTHMA ?
Due to lymphatic leukemia
Other conditions RHEUMATOID ARTHRITIS
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no.
Accident, suicide, or homicide - Date of -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -

23. SIGNATURE [Signature] M. D. or other 9/1/45
Address Cambr. Md. Date signed 9/1/45

RECEIVED
SEP 17 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Re-A*

CERTIFICATE OF DEATH

07999

Reg. Dist. No. *116*

1. PLACE OF DEATH:

County *Dorchester*City or town *Cambridge*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *3 days*

Hospital, institution, or street address where death occurred:

*Cambridge Hospital*How long in hospital or institution? *3 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) if veteran, name war.....

3. (a) FULL NAME

Edward Richards

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.) *Unknown*

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace.....

*Seymour**Delaware*

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

Anna Richards

13. Birthplace.....

Delaware

MOTHER

14. Maiden name.....

Bella

15. Birthplace.....

Delaware

16. Informant.....

Address.....

17.

William Sims

Date thereof.....

8-8-45
(month) (day) (year)

Cemetery or crematory.....

Cemetery

Location.....

Cambridge Md

18. Funeral director.....

Lewis H. Bannister

Address.....

Cambridge Md

19.

8-7-45
(Date rec'd by registrar)

19.

John MacC...
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *August 5* 19*45*, at *6:10 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1st 19*45* to *Aug 5* 19*45*and that I last saw him alive on *August 4* 19*45*

Immediate cause of death.....

Wernia

DURATION

1 day

Due to.....

*Coronary fibrillation**1 day*

Due to.....

*Cardiac decompensation**4 days*

Diber conditions.....

*Incarcerated from 10/1/44**4 days*(left - hypopharynx)
(Include pregnancy within 3 months of death)

Major findings of operation.....

Incarcerated & obstructed loop
of small intestine w/ left hernia Date of op. *8-2-45*

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... *Cambridge Md* Date signed *8-8-45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 11 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(2nd)

089000

CERTIFICATE OF DEATH



Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town East New Market - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Near Shiloh
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town East New Market - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Shiloh
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

Charles Thomas

3. (b) Social Security Number

None

| | | | |
|--|------------------------------------|--|--|
| 4. Sex <u>Male</u> | 5. Color or race <u>Colored</u> | 6. (a) Single, married, widowed, or divorced <u>Married</u> | |
| 6. (b) Name of husband or wife <u>Annie Thomas</u> | | 6. (c) If alive, give age <u>79</u> years | |
| 7. Birth date of deceased (mo., day, yr.) <u>June 15, 1868</u> | | | |
| 8. AGE: Years <u>77</u> | Months <u>1</u> | Days <u>26</u> | If less than one day hrs. min. |

9. Birthplace Dorchester County, Maryland
 (Town, county, and state)
 10. Usual occupation Farm laborer
 11. Industry or business Farm

FATHER
 12. Name Henry Thomas
 13. Birthplace Dorchester County, Maryland
 MOTHER
 14. Maiden name Milby Earles
 15. Birthplace Dorchester County, Maryland
 16. Informant Mrs. Annie Thomas
 Address East New Market, Maryland, R.F.D.
 17. Burial
 (Burial, cremation, or removal. Which?) Date thereof August 14, 1945
 (month) (day) (year)
 Cemetery or crematory Thompsonstown Cemetery
 Location Near East New Market, Maryland
 18. Funeral director J. K. Thompson and Son
 Address Fredericksburg, Maryland
 19. Aug. 13, 1945 Chas. W. Hastings
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1945 at 2:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from since May 1944
 and that I last saw him alive on Aug 10, 1945

Immediate cause of death Chronic Endo
Carditis
 Due to some nephritis
 Other conditions some nephritis
 (Include pregnancy within 8 months of death)

Major findings of operations - Date of op. -
 Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? - (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -
 23. SIGNATURE L. J. Thomas M. D. or other
Wm. H. Mc
 Address - Date signed Aug. 13, 1945

RECEIVED
AUG 17 1945
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

CERTIFICATE OF DEATH

08901

Reg. Diat. No. 116

1. PLACE OF DEATH: Dorchester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Cambridge Maryland Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland..... County.....Dorchester
 City or town.....Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Washington St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Samuel F. Thompson

3. (b) Social Security Number

4. Sex.....Male.....
 5. Color or race.....Colored.....
 6.(a) Single, married, widowed, or divorced.....married.....

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....1875.....
 8. (c) If alive, give age.....years.....

8. AGE: Years.....70..... Months.....#..... Days.....#.....
 If less than one day.....hrs.....min.....

9. Birthplace.....Maryland
 (Town, county, and state)

10. Usual occupation.....Laborer

11. Industry or business.....

MOTHER FATHER
 12. Name.....Samuel Thompson
 13. Birthplace.....Taylor Island, Md
 14. Maiden name.....Hester Smith
 15. Birthplace.....Camb. Md.

18. Informant.....Mary Leene
 Address.....Cambridge, Md.

17. (Burial, cremation, or removal. Which?).....Burial..... Date thereof.....8-19-45
 (month) (day) (year)
 Cemetery or crematory.....Taylor Island Cemetery
 Location.....Taylor Island, Md

18. Funeral director.....Lewis H. Bayneum
 Address.....Cambridge Md.

19. 8-16-.....40.....John.....Thompson.....Md
 (Date rec'd by registrar) (Age) (Signature) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....August 15.....1945.....at.....7-45 P.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19.....to.....19.....
 and that I last saw h.....alive on.....19.....

Immediate cause of death.....Shock.....
 Due to.....Struck by falling tree.....
 Due to.....tree.....

Other conditions.....
 (Include pregnancy within 8 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....Accident..... Date of.....Aug 15/45
 Where did injury occur.....Cambridge, Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....in woods
 Means of injury.....Falling tree..... Injured at work?.....yes
 23. SIGNATURE.....J. H. Shivers, Dep. Med. Ex.
 M. D. or other.....
 Address.....Cambridge, Md..... Date signed.....Aug 15/45

RECEIVED

AUG 18 1945

BUREAU T.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08002

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Mths.

Hospital, institution, or street address where death occurred:

10 Light St.

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Locust St.
(If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME

Hannah Smith Todd

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Cleveland R. Todd

6.(c) If alive, give age 61 years

7. Birth date of

deceased (mo., day, yr.) Sept. 23, 1884.

8. AGE:

Years

60

Months

10

Days

15

If less than one day

hrs. min.

9. Birthplace Selbyville, Delaware

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name Not Known

13. Birthplace II

14. Maiden name II

15. Birthplace II

18. Informant Cleveland R. Todd

Address 319 Locust St., Cambridge, Md.

17. Burial Aug. 10, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Donoway Family Cemetery

Location Selbyville, Delaware

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 8-10- 1945 John H. Todd, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1945 at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to 1945

and that I last saw him alive on 1945

Immediate cause of death

DURATION

Disease of Coronary Arteries

Due to

1 day

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. R. Shriver, Dep. Med. Exam.
M. D. or other

Address Cambridge, Md. Date signed Aug 9/45

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 11 1945
BUREAU V.S.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
is shown on

2411 N. Charles St., Baltimore 93d

08003

FILED N G 97 SEP 10 1945

CERTIFICATE OF DEATH

Reg. Diat. No. 116 119

1. PLACE OF DEATH:

County Dorchester
City or town Rural-Bishops Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
Bishops Head
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Rural-Toddville
(If outside city or town limits, write RURAL and give nearest town)
Toddville
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Susie Pritchett Todd

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife James E. Todd

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1866

8. AGE: Years 78 Months -79- Days -1- 11 If less than one day 13 hrs. _____ min. _____

9. Birthplace Bishops Head, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Zebedee Pritchett

13. Birthplace Bishops Head, Md.

14. Maiden name Margaret Moore

15. Birthplace Bishops Head, Md.

16. Informant Mrs. Elsa Layton

Address Cambridge, Maryland.

17. Burial Aug. 23, 1945

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Zion Church Cemetery

Location Toddville, Maryland.

18. Funeral director Leconte's Funeral Service

Address Cambridge, Maryland.

19. Aug 22 19 45 Wilson & Pritchett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

08004

CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH:

County Dorchester
City or town East New Market
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town East New Market
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name War

3. (a) FULL NAME

George Albert Young

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Mar 3 18 99

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

465

hrs.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

John R Young

13. Birthplace

MD

MOTHER

14. Maiden name

Emma M. Young

15. Birthplace

MD

16. Informant

John R Young

Address

East New Market

17.

(Burial, cremation, or removal, which?)

Date thereof

Aug 29 1945

Cemetery or crematory

Cemetery

Location

East New Market

18. Funeral director

J. B. Kilgough

Address

East New Market

19.

Aug 28 19 45

Eligible at C Smith

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 2619 45 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 2619 45 to

19

and that I last saw him alive on Aug 2619 45

Immediate cause of death

Apoplexy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. D. Brown M.D.

M. D. of other

Address

East New Market

Date signed

8/28/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED

SEP 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

930

08005

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Yrs.

Hospital, institution, or street address where death occurred:

Ross Neck, RFD # 3How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Ross Neck, RFD # 3
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Harry B. Young

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife —6. (c) If alive, give age — years

7. Birth date of

deceased (mo., day, yr.) 1878

8. AGE:

67Months —Days —

If less than one day

— hrs.— min.

8. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Dirt

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant Mr. Everett MarshallAddress RFD # 3, Cambridge, Md.17. (Burial, cremation, or removal. Which?) BurialDate thereof 8-22-45
(month) (day) (year)Cemetery or crematory Kenneth Square CemeteryLocation Kenneth Square, Pa.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 8-21-45
(Date rec'd by registrar)Registrar John M. Mays, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 19 45, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

— 19 —, to — 19 —and that I last saw him — alive on — 19 —

Immediate cause of death

DURATION

Chronic Myocarditis ?Due to —Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE Dr. J. H. Spriner, Dep. Med. Exam.

M. D. or other

Address Cambridge, Md. Date signed Aug 20/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1965

BUREAU V. A.